

PATIENT REGISTRATION INFORMATION/AUTHORIZATION

PATIENT INFO New/Update Date: _____

Name (Last) _____ (First) _____
(Middle) _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: ____/____/____ SS#: ____/____/____ Race: _____
Sex M F

Home#: (____) _____ - _____ Cell#: (____) _____ - _____ Marital Status: S M
W D

Alternative Contact: _____ Phone: _____

Patient's Employer: _____ Occupation: _____

Address: _____ Phone: _____

Spouse's Name: _____

DOB: ____/____/____ SS#: ____/____/____

Spouse's Employer: _____ Occupation: _____

Address: _____ Phone: _____

Referring

MD: _____ Phone: _____

Address: _____ City _____ State: _____
_____ Zip _____

PCP (If different from Ref.
MD) _____ Phone: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

COMPANY: _____

ID#: _____

GROUP#: _____

Primary Insured's
Name/Relationship: _____

SECONDARY INSURANCE

COMPANY: _____

ID#: _____

GROUP#: _____

Insured's Name/Relationship:

By signing below I hereby authorize Nephrology Associates to release any protected or individually identifiable health information to other Providers, Facilities, or Individuals involved with my treatment or the payment thereof, as described in the privacy policies statement of Nephrology Associates. I further request that payment of authorized Medicare / Medigap / Medicaid / other insurance company benefits be made directly to Nephrology Associates for any service furnished to me, and hereby assign said benefits to them. I understand that I am required by law (Section 1128B SS Act & U.S.C. 3801-3812) to inform Nephrology Associates of any other party that may be responsible for paying for services provided to me.

Signature of Patient/Guardian

Co-pays and deductibles are expected to be paid at the time of service. Thank you!